

Medicare Secondary Payer (MSP) Manual

Chapter 3 - MSP Provider Billing Requirements

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(Rev. 25, 02-25-05,)

(Rev. 26, 03-04-05)

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10 - General

(Rev. 1, 10-01-03)

B3-3328.15, A3-3491.14, HO-263.14, SNF-336.14, HH-253.13, B3-3329.10

Contractors are required in professional and public relations activities to inform providers, physicians, and beneficiaries about the MSP provisions and that claims from beneficiaries for which Medicare is the secondary payer must be directed first to the Third Party Payer (TPP) where there is primary coverage for the services involved. The Medicare law requires the submitter to identify on the claim all known payers obligated to pay primary to Medicare.

10.1 - Definitions of Provider of Service, Health Care Provider, and Supplier of Services

(Rev. 1, 10-01-03)

The following billing instructions may apply to all or a subset of providers of services, health care providers or suppliers of services. To distinguish instructions applicable for each group and facilitate understanding, the terms are defined below and will be used to reference a subset.

A - Provider of Service

Provider of service means a hospital, SNF, HHA, CORF, hospice, and for the limited purpose of furnishing outpatient physical therapy or speech pathology services, a clinic, rehabilitation agency, or public health agency which meets applicable eligibility requirements under title XVIII of the Social Security Act (the Act) and related regulations.

B - Health Care Provider

Health care provider means providers of services (defined above), suppliers, doctors, nonphysician practitioners, and anyone else who furnishes a health care service.

C - Supplier of Services

Supplier of services includes physicians, practitioners, etc., as well as those suppliers usually referenced, such as DME suppliers.

10.2 - Limitation on Right to Charge a Beneficiary

A3-3491.7, A3-3490.11, A3-3497.8, HO-263.8, HO-264.14, SNF-336.8, SNF-335.14, HH-252.14, HH-253.8

(Rev. 1, 10-01-03)

A - Limitation on Right of Provider or Facility to Charge a Beneficiary

A participating provider of service or any other facility that receives direct payment from the Medicare program may not charge a beneficiary or any other party other than an insurer which is primary under §1862(b) of the Act for Medicare covered services if the provider or facility has been paid or could have been paid by a GHP an amount which equals or exceeds any applicable deductible or coinsurance amount. This applies where an insurer is made primary under §1862(b) of the Act but offers only secondary benefits.

EXAMPLE

A Medicare beneficiary who had GHP coverage was hospitalized for 20 days in 2003. The hospital's charges for covered services were \$5000. The inpatient deductible had not been met. The gross amount payable by Medicare (as defined in Chapter 2, §50.2) **for the stay if there had been no GHP coverage is \$4,000.** The GHP paid \$4,500 (\$840. of which was credited to the Medicare deductible). Medicare will make no payment, since the plan's payment was greater than Medicare's gross amount payable of \$4,000. No part of the \$500 difference between the hospital's charges and the GHP's payment can be billed to the beneficiary since the beneficiary's obligation, the deductible, was met by the GHP payment. The provider of service submits a bill to Medicare reflecting the appropriate amount paid by the primary payer.

B - Right of Provider to Charge Beneficiary Who Has Received Third Party Payment

A3-IM 3497.8 (This supersedes §3490.11 and §3491.7), HO-263.8, HO-264.14, SNF-335.14, SNF-336.8, HH-253.8, HH-252.14

When a third party payer has paid a beneficiary, the amounts the provider (including renal dialysis facilities or facilities that receive direct payment from the Medicare program) may collect for Medicare covered services from the beneficiary are limited to the following:

- The amount paid or payable by the third party payer to the beneficiary. If this amount exceeds the amount which would have been payable by Medicare as primary payer (without regard to deductible or coinsurance), the provider may retain the third party payment in full without violating the terms of the provider agreement;
- The amount, if any, by which the applicable Medicare deductible and coinsurance amounts exceed any third party payment made or due the beneficiary or due the provider for medical services; and

- The amount of any charges made to the beneficiary for the noncovered component of a partially covered service, e.g., the charge differential for a private room that is not medically necessary but that is requested by the beneficiary. However, such a charge may not be collected from the beneficiary to the extent that the third party payer pays it directly to the provider.

EXAMPLE

A Medicare beneficiary with GHP coverage was a hospital inpatient for 20 days in 2000. The hospital's charges for Medicare covered services were \$16,000. The inpatient deductible had not been met. The gross amount payable by Medicare for the stay in the absence of GHP coverage is \$11,500. The employer's plan paid \$14,000, a portion of which was credited to the entire inpatient deductible. Medicare makes no secondary payment, since the plan's payment was greater than the gross amount payable by Medicare of \$11,500. No part of the \$2,000 difference between the hospital's charges and the employer plan's payment can be billed to the beneficiary, since the beneficiary's obligation, the deductible, was met by the employer plan's payment. The provider files a nonpayment bill reflecting the applicable deductible for purposes of crediting the deductible.

10.2.1 - Right of Physician or Supplier to Charge Beneficiary

(Rev. 1, 10-01-03)

A3-3328.24

A - Basic Rule

When a beneficiary has been paid by a TPP, the amount a physician/supplier who accepts assignment may collect for Medicare covered services from the beneficiary is limited to the following:

- The amount paid or payable by the TPP to the beneficiary. (If this amount exceeds the amount that would be payable by Medicare as primary payer (without regard to deductible or coinsurance), the physician or supplier may retain the third party payment in full without violating the conditions of assignment.); or
- If the third party payment is less than the applicable Medicare deductible and coinsurance amounts, the difference between the fee schedule amount (or the amount the physician is obligated to accept as payment in full, if less) and the sum of the third party primary payment and the Medicare secondary payment.

EXAMPLE

A physician charges \$262 for a service. The plan allows \$262 but pays a primary payment of only \$112 because of a \$150 plan deductible. The Medicare fee schedule amount is \$200. The amount that Medicare pays as secondary payer is \$80 since the Medicare secondary payment amount cannot exceed the amount Medicare would pay as

primary payer (\$200 fee schedule amount minus the \$100 Part B deductible equals \$100 x 80 percent = \$80). The combined primary plan payment and Medicare secondary payment is \$192 (\$112 + \$80).

The physician may charge the beneficiary \$8, the difference between the Medicare fee schedule amount (\$200) and the sum of the primary payment (\$112) plus the Medicare secondary payment (\$80). The \$8 charge to the beneficiary represents the portion of the Part B deductible and coinsurance amounts in excess of the plan payment. The \$100 Part B deductible is credited in full. The remaining \$12 of the plan payment is applied to the beneficiary's Part B coinsurance obligation of \$20, leaving the beneficiary responsible for the remaining coinsurance obligation of \$8.

In the case of noninpatient and institutional psychiatric services, the amount the beneficiary can be charged is the difference between the Medicare fee schedule amount and a lesser third party payment amount. (The 50-percent cost-sharing rule applies.) The beneficiary is responsible for that portion of the fee schedule amount not paid by Medicare (i.e., no less than 50 percent). (See Chapter 1, §40.)

B - Right to Charge Beneficiary When Physician or Supplier Has Failed to File Proper Claim

If a physician/supplier receives from a payer that is primary to Medicare a payment that is reduced because the physician/supplier failed to file a proper claim, the physician/supplier may charge the beneficiary an amount equal to any third party payment reduction attributable to failure to file a proper claim if the beneficiary was the sole cause of the failure. The physician/supplier may charge the beneficiary this amount only if the physician/supplier can show that a proper claim was not filed due to the beneficiary's action or inaction and the beneficiary is not mentally or physically incapacitated. (See Chapter 1, §30.1)

10.3 - Situations in Which MSP Billing Applies

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

Medicare secondary billing procedures apply in the following situations:

- Where the VA authorized services, Medicare does not make payment for items or services furnished by a non-Federal provider pursuant to such an authorization. Although certain MSP billing procedures apply, VA is not an MSP provision. (See the Medicare Benefit Policy Manual, Chapter 17, §50.1, for an explanation of this provision.);
- Where services are payable under WC, Medicare does not make payment for any items and services to the extent that payment has been made, or can reasonably be expected to be made, for such items or services under a WC law or plan of the United States or a State. (See Chapter 1 for an explanation of this provision.) *Under certain circumstances, Medicare may make conditional payments if the WC carrier has not paid or will not pay promptly;*

- Where services are payable under no-fault or liability insurance, Medicare does not make payment for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made for the items or services under no-fault *or liability* insurance (including a self-insured plan). *Under certain circumstances, Medicare may make conditional payments if the no fault or liability insurer has not paid or will not pay promptly.* Medicare is secondary to no-fault insurance even if State law or a private contract of insurance stipulates that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries. In the case of liability insurance, if CMS has information that services for which Medicare benefits have been claimed are for the treatment of an injury or illness that was allegedly caused by a person who is insured under a liability insurance plan, Medicare benefits *may be paid* conditionally and then recovered. (See Chapter 5, §§40.6);
- Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to Medicare based on ESRD during a Medicare coordination period as described in Chapter 1, §10.2;
- Medicare benefits are secondary to benefits payable under a GHP for individuals age 65 or over who have GHP coverage as a result of their own current employment status or the current employment status of a spouse of any age. (See Chapter 1, §10.1, for an explanation of this provision.); and
- Medicare benefits are secondary to benefits provided by GHPs for certain disabled individuals under age 65 (entitled to Medicare on the basis of disability) who have coverage based on their own current employment status or the current employment status of a family member, e.g., a spouse or other family member of a disabled beneficiary. (See Chapter 1, §10.3, for an explanation of this provision.)

Payment made by any of these primary payers can be used to satisfy unmet deductibles and the individual's coinsurance. Inpatient, psychiatric hospital, SNF, or Religious Non-medical Institution care that is paid for by a primary payer is not counted against the number of lifetime psychiatric days available to the beneficiary.

10.4 - Provider Responsibility When a Request is Received From an Insurance Company or Attorney

(Rev. 1, 10-01-03)

A3-3489.2.C, HO-262.4, HO-262.10, SNF-332.4, SNF-334.2, HH-248.2, HH-251.4

The provider notifies the Coordination of Benefits Contractor (COBC) promptly if a request is received from an attorney or an insurance company for a copy of a medical record or a bill concerning a Medicare patient. The COBC is given a copy of the request or, if it is unavailable, details of the request, including:

- The name and Medicare number of the patient;

- Name and address of the insurance company and/or attorney; and,
- Date(s) of services for which Medicare has been or will be billed.

Contractors receiving MSP information from providers should follow the procedures outlined in Chapter 4, "Coordination of Benefits Contractor (COBC) Requirements," §70.2.

10.5 - Provider Responsibility When Duplicate Payments Are Received

(Rev. 1, 10-01-03)

B3-3328.24.C, A3-3489.2.D, A3-IM3497.9, HO-262.4, HO-262.10, HO-289.24, SNF-332.4, HH-250.23, SNF-334.2, HH-248.2, HH-251.4, HO-484.7

In any case in which a provider, physician, or supplier has received a primary payment from Medicare and a duplicate primary payment from a TPP, the contractor instructs the provider, physician, or supplier to refund to the beneficiary any Medicare deductible and coinsurance amounts paid by the beneficiary that were duplicated by the third party payment. If the third party payment exceeds the deductible and coinsurance amounts, the excess constitutes a debt to Medicare because it duplicates all or part of the amount Medicare has paid and, therefore, must be collected from the provider, physician, or supplier. Medicare must be reimbursed within 60 days of the receipt of the duplicate payment. A copy of the letter to the provider, physician, or supplier is sent to the beneficiary. Interest is applicable if repayment is not made to Medicare within 60 days.

The MSP regulations at 42 CFR 489.20 require providers to pay Medicare within 60 days from the date a payment is received from another payer (primary to Medicare) for the same service for which Medicare paid. A provider of service refunds the Medicare payment within 60 days by submitting an adjustment bill or via the Medicare Credit Balance Report. A supplier of service submits a refund check to Medicare. This refund is due Medicare, regardless of which payment the provider received first and even if the insurance payment was refunded to the beneficiary or the insurer.

Providers of service report credit balances resulting from MSP payments on the Form CMS-838 if the overpayment has not been repaid by the last day of the reporting quarter. If the provider identifies and repays an MSP credit balance within a reporting quarter, in accordance with the 60-day requirement, it is not reported on the Form CMS-838, i.e., once payment is made, a credit balance would no longer be reflected in the provider records.

If an MSP credit balance occurs late in a reporting quarter, and the Form CMS-838 is due prior to expiration of the 60-day requirement, the overpayment must be included in the credit balance report. However, payment of the credit balance does not have to be made at the time the Form CMS-838 is submitted, but within the 60 days allowed.

10.6 - Incorrect GHP Primary Payments

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

The contractor may advise claimants that a GHP has incorrectly paid primary benefits, e.g., primary payments made by the GHP of an employer of less than 20 employees. In such cases, the claimant bills Medicare as primary payer if the Medicare timely filing period has not expired and refunds to the GHP any amount it paid in excess of the Medicare deductible and coinsurance amounts and charges for non-covered services.

A GHP may advise a claimant that the GHP believes that Medicare may have been the proper primary payer for services for which the GHP had previously made a primary payment. The GHP may request that the claimant either submit an initial claim to Medicare or request that Medicare reopen its determination on previously submitted claims for the services. The normal Medicare timely filing and reopening rules apply to these situations. The initial claim must be submitted within the timely filing period. An initial determination on a previously adjudicated claim may be reopened for any reason for 1 (one) year from the date of that determination. After 1 (one) year and prior to 4 (four) years from the date of determination, "good cause" is required for Medicare to reopen the claim. In general, Medicare does not consider a situation where (a) Medicare processed a claim in accordance with the information on the claim form and consistent with the information in the Medicare's systems of records and; (b) a third party mistakenly paid primary when it alleges that Medicare should have been primary to constitute "good cause" to reopen.

10.7 - Retroactive Application

(Rev. 1, 10-01-03)

HO-264.3, SNF-335.3, HH-252.3

If a contractor including the COBC notifies the claimant (provider, physician, or supplier), or the claimant learns from other sources that an employer plan may be primary payer for services for which Medicare paid primary benefits, the claimant takes the following actions:

- Ascertains whether there is GHP coverage and if so, the name and address of the GHP, if that information is not annotated on the claim;
- Checks its records to ascertain whether Medicare paid primary benefits for other services rendered during a coordination period for which a GHP may be primary; and
- Notifies the COBC of the results of the development efforts according to Chapter 4, "Coordination of Benefits Contractor (COBC) Requirements," §10.3.

This information is necessary for Medicare to determine its proper payment. If the employer plan pays or has already paid the claimant for all or part of the services, the

claimant submits a corrected bill to the contractor along with the employer plan's explanation of benefits (EOB). The contractor recoups from the claimant the amount of Medicare benefits paid in excess of any amount it is obligated to pay as secondary payer.

10.8 – Medicare Health Maintenance Organization (HMO) Contracts

(Rev. 1, 10-01-03)

A3-3418.29

HMOs and competitive medical plans (CMPs) that contract with CMS on a cost basis, are required, under 42 CFR 417.528 to identify MSP situations and coordinate benefits of its Medicare enrollees with these payers. These are the same procedures that FIs and carriers perform for MSP situations.

If it is determined that payments have been made by both the cost contract HMO and Medicare FIs and carriers, the entity that paid the most in benefits will assume responsibility for coordinating with the other entities to develop the total Medicare conditional payments made and initiate recovery activities. For example, if the Medicare contractor is determined to have paid the most in benefits, development with both the cost-contract HMO and/or other contractors involved is necessary. It is essential that the amount said to be Medicare's claim represents the total of any Part A and B Medicare services provided to the beneficiary.

Identification of cost contract HMO/CMP Medicare enrollees is normally determined from CWF response trailers designating the contract number, and payment option codes 1 or 2.

HMOs that are paid on a risk basis by CMS should also identify MSP situations and coordinate benefits of Medicare enrollees. These are the same procedures that FIs and carriers perform for MSP situations. Risk contract HMOs should follow Medicare guidelines in the development and recovery of conditional payments made, including provision of appeal and waiver of recovery rights. Currently, any request for waiver of recovery under §1870(c) of the Act based on financial hardship or equity and good conscience must be developed by the HMO and forwarded to the CMS regional office. Any request for compromise, suspension, or termination of a debt under the Federal Claims Collection Act (31 USC 3711) must also be forwarded to the RO with the complete file.

20 - Obtain Information From Patient or Representative at Admission or Start of Care

(Rev. 25, Issued: 02-25-05, Effective: 04-25-05, Implementation: 04-25-05)

20.1 - General Policy

(Rev. 26, Issued: 03-04-05, Effective: 06-06-05, Implementation: 06-06-05)

Based on the law and regulations, providers, physicians, and other suppliers are required to file claims with Medicare using billing information obtained from the beneficiary to whom the item or service is furnished. Section 1862(b)(6) of the Act, (42 USC 1395y(b)(6)), requires all entities seeking payment for any item or service furnished under Part B to complete, on the basis of information obtained from the individual to whom the item or service is furnished, the portion of the claim form relating to the availability of other health insurance. Additionally, 42 CFR 489.20(g) requires that all providers must agree "...to bill other primary payers before billing Medicare..."

Thus, any providers, physicians, and other suppliers that bill Medicare for services rendered to Medicare beneficiaries must determine whether or not Medicare is the primary payer for those services. This must be accomplished by asking Medicare beneficiaries, or their representatives, questions concerning the beneficiary's MSP status. Exceptions to this requirement are discussed below in 1 and 3. If providers, physicians or other suppliers fail to file correct and accurate claims with Medicare, and a mistaken payment situation is later found to exist, 42 CFR 411.24 permits Medicare to recover its conditional or mistaken payments.

Section 20.2.1, "Admission Questions to Ask Medicare Beneficiaries," may be used to determine the correct primary payers of claims for all beneficiary services furnished by a hospital.

NOTE: Providers are required to determine whether Medicare is a primary or secondary payer for each inpatient admission of a Medicare beneficiary and outpatient encounter with a Medicare beneficiary prior to submitting a bill to Medicare. It must accomplish this by asking the beneficiary about other insurance coverage. Section 20.2.1 lists the type of questions it must ask of Medicare beneficiaries for **every** admission, outpatient encounter, or start of care. Exceptions to this requirement are discussed below in 1 and 3.

EXCEPTIONS

These questions may be asked in connection with online access to Common Working File (CWF). (See §20.2.) If the provider lacks access to CWF, it will follow the procedures found in §20.2.1.

NOTE: There may be situations where more than one payer is primary to Medicare (e.g., automobile insurer and GHP). The provider, physician, *or other* supplier must identify all possible payers.

This greatly increases the likelihood that the primary payer is billed correctly. Verifying MSP information means confirming that the information previously furnished about the presence or absence of another payer that may be primary to Medicare is correct, clear, and complete, and that no changes have occurred.

1. Policy for Hospital Reference Lab Services and Independent Reference Lab Services

Background

Section 943 (TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYER (MSP) PROVISIONS) of the Medicare Prescription Drug, Improvement & Modernization Act of 2003 states:

“(a) IN GENERAL. – The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to Medicare Secondary Payer provisions) in the case of reference lab services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

“(b) REFERENCE LABORATORY SERVICES DESCRIBED. – Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.”

Policy

The Centers for Medicare & Medicaid Services (CMS) will not require independent reference laboratories to collect MSP information in order to bill Medicare for reference laboratory services as described in subsection (b) above. Therefore, pursuant to section 943 of The Medicare Prescription Drug, Improvement & Modernization Act of 2003, CMS will not require hospitals to collect MSP information in order to bill Medicare for reference laboratory services as described in subsection (b) above. This policy, however, will not be a valid defense to Medicare’s right to recover when a mistaken payment situation is later found to exist.

Intermediaries and carriers shall instruct hospital and independent labs, which have already collected and retained MSP information for beneficiaries, that they may use that information for the billing of non-face-to-face reference lab services. However, in situations when there is a face-to-face encounter with the beneficiary, intermediaries and carriers shall instruct hospitals and independent labs that they are required to collect MSP information from the beneficiary when billing for lab services.

Instructions to carriers on how to process reference lab claims submitted on Form CMS-1500 are available by clicking on the following hyperlink:
http://www.cms.hhs.gov/manuals/104_claims/clm104c26.pdf (After you get to chapter 26, click on section 10.2 in the Table of Contents.)

2. Policy for Recurring Outpatient Services

A-02-021

Hospitals must collect MSP information from the beneficiary or his/her representative for hospital outpatients receiving recurring services. Both the initial collection of MSP information and any subsequent verification of this information must be obtained from the beneficiary or his/her representative. Following the initial collection, the MSP information should be verified once every 90 days. If the MSP information collected by the hospital, from the beneficiary or his/her representative and used for billing, is no older than 90 calendar days from the date the service was rendered, then that information may be used to bill Medicare for recurring outpatient services furnished by hospitals. This policy, however, will not be a valid defense to Medicare's right to recover when a mistaken payment situation is later found to exist.

NOTE: A Medicare beneficiary is considered to be receiving recurring services if he/she receives identical services and treatments on an outpatient basis more than once within a billing cycle.

Hospitals must be able to demonstrate that they collected MSP information from the beneficiary or his/her representative, which is no older than 90 days, when submitting bills for their Medicare patients. Acceptable documentation may be the last (dated) update of the MSP information, either electronic or hardcopy.

3. Policy for Medicare + Choice Organization (M+CO) Members

If the beneficiary is a member of an M+CO, hospitals are not required to ask the MSP questions or to collect, maintain, or report this information.

4. Policy for Medicare Secondary Payer (MSP) Retirement Dates

During the intake process, when a beneficiary cannot recall his/her precise retirement date as it relates to coverage under a group health plan as a policyholder or cannot recall the same information as it relates to his/her spouse, as applicable, hospitals must follow the policy below.

When a beneficiary cannot recall his/her retirement date but knows it occurred prior to his/her Medicare entitlement dates, as shown on his/her Medicare card, hospitals report his/her Medicare A entitlement date as the date of retirement. If the beneficiary is a dependent under his/her spouse's group health insurance and the spouse retired prior to the beneficiary's Medicare Part A entitlement date, hospitals report the beneficiary's Medicare entitlement date as his/her retirement date.

If the beneficiary worked beyond his/her Medicare A entitlement date, had coverage under a group health plan during that time, and cannot recall his/her precise date of retirement but the hospital determines it has been at least five years since the beneficiary

retired, the hospital enters the retirement date as five years retrospective to the date of admission. (Example: Hospitals report the retirement date as January 4, 1998, if the date of admission is January 4, 2003) As applicable, the same procedure holds for a spouse who had retired at least five years prior to the date of the beneficiary's hospital admission. If a beneficiary's (or spouse's, as applicable) retirement date occurred less than five years ago, the hospital must obtain the retirement date from appropriate informational sources; e.g., former employer or supplemental insurer.

5. Policy for Provider Records Retention of MSP Information

Title 42 CFR 489.20(f) states that the provider agrees to maintain a system that, during the admission process, identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented. Based on this regulation, hospitals must document and maintain MSP information for Medicare beneficiaries. Without this documentation, the intermediary would have nothing to audit submitted claims against. CMS recommends that providers retain MSP information for 10 years.

A - Obtain Auto, Non-Auto Liability or No-Fault Insurance Information

Providers are required to obtain information on possible Medicare Secondary Payer situations. Medicare patients, or their representatives, at admission or start of care, are asked if the services are for treatment of an injury or illness which resulted from an automobile accident or other incident, for which auto, liability or no-fault insurance may pay, or for which another party is held responsible. This includes an incident that occurs on the provider's premises. The provider obtains the name, address, and policy number of any automobile or non-automobile liability or no-fault insurance company or any other party that may be responsible for payment of medical expenses that resulted from the accident or illness.

B - Obtain Workers' Compensation (WC) Information

Providers are expected to inquire of the beneficiary or representative at the time hospitalization is ordered, at admission, or when the service is rendered, whether the condition is work-related. When the patient or the patient's physician indicates that the condition is work-related or there is other indication that it is work-related, the provider is required to ask the patient or the patient's physician, wherever possible, whether WC is expected to pay. (Generally, where hospital services are covered under a WC program, the WC carrier or the employer will authorize the services in advance.)

If the patient denies that WC benefits are payable for a condition which the provider believes may be covered by WC, a supplementary statement is attached to the billing form containing information about the circumstances of the accident and the reasons it is claimed that WC benefits are not payable.

C - Obtain GHP Data from Working Aged Beneficiaries

To obtain the information needed to ascertain whether to bill a GHP as primary payer, providers ask beneficiaries age 65 or over admitted for inpatient care or receiving outpatient care, or their representatives, selected questions. See Chapter 4, §30.4.2.1, of this MSP manual for the model questionnaire. These include the age of the beneficiary, the employment status of the beneficiary and the spouse, whether the beneficiary is covered under a GHP because of the beneficiary's or the spouse's current employment, and the patient's identification number and the name and address of the GHP.

D - Obtain GHP Data from Disabled Beneficiaries

Providers are required to identify individuals who meet the disability provisions by asking every Medicare beneficiary under age 65 if the individual has group health coverage based on their own current employment status or the current employment status of a family member. If the individual has such coverage, the provider requests the name and address of the employer plan and the individual's identification number and bills the plan for primary benefits, except where the provider has information that clearly shows that the employer plan is not primary payer. If the individual responds negatively to either question, or the provider has otherwise determined that the employer plan is not primary payer, the provider bills Medicare for primary benefits.

E - Obtain GHP Data from ESRD Beneficiaries

Health care providers identify beneficiaries who are entitled to Medicare based on ESRD through information available to them (e.g., the beneficiary's Medicare card) and to ascertain whether the services may be payable under a GHP during the 30-month coordination period. Providers determine whether the services were rendered in the coordination period by checking their own records, e.g., information contained on Form CMS-2728 or, if the potential Medicare payment is \$50 or more, with other providers or facilities, or the beneficiary's physician, if necessary, to determine the date the individual started a regular course of dialysis or the date the individual received a kidney transplant (or entered a hospital to receive a transplant) or the date an individual began a course of home dialysis. If the individual is in the 30-month coordination period, the provider asks if the beneficiary is insured under a group health insurance plan of his or her own, or as a family member. If the response is yes, the provider asks for the name and address of the plan and the beneficiary's identification number. A coordination of benefits (COB) period may be applicable even if an ESRD beneficiary or his (her) spouse is not currently employed throughout the COB period. The beginning date of a COB period is different when an individual receives a kidney transplant or receives home dialysis than when an individual receives regular (outpatient) dialysis (3-month waiting period).

If the information obtained does not indicate GHP coverage, the provider annotates the bill to that effect (e.g., GHP coverage lapsed, benefits exhausted). If the information indicates that GHP coverage exists, the provider obtains the

information indicated above from the beneficiary or the beneficiary's representative.

For audit purposes, and to ensure that the provider has developed for other primary payer coverage, the provider retains a record of the development or other information on which it based its determination that Medicare is primary payer. See Chapter 5, §30, for action to take where a claim is received for primary benefits and there is reason to believe that Medicare may be secondary payer.

20.2 - Verification of Medicare Secondary Payer (MSP) Online Data and Use of Admission Questions

(Rev. 1, 10-01-03)

HO-301.1

MSP Online Data Elements

Providers with online capability may now access the following MSP information via CWF from the CWF MSP auxiliary file:

- MSP effective date;
- MSP termination date;
- Patient relationship;
- Subscriber name;
- Subscriber policy number;
- Insurer type;
- Insurer information: Name, group number, address, city, State, and ZIP code;
- MSP type;
- Remarks code;
- Employer information: Name, address, city, State, and ZIP code (for all contractors, with the exception of 77777); and
- Employee data: ID number, and information.

At the provider's discretion, these data may be viewed during either the admission or the billing process. However, the data must be viewed before a bill is submitted to Medicare, and should ideally be viewed before the patient leaves the hospital.

If used during admission, the provider will verify each data element by using the questions found in §20.1 to help identify other payers that may be primary to Medicare. It will comply with any instructions that follow a particular question.

20.2.1 - Admission Questions to Ask Medicare Beneficiaries

(Rev. 1, 10-01-03)

HO-301.2

The following chart lists questions to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers use this chart as a guide to help identify other payers that may be primary to Medicare. Beginning with Part 1, they ask the patient each question in sequence. They comply with any instructions that follow an answer. If the instructions direct them to go to another part, they have the patient answer, in sequence, each question under the new part.

Part I

1. Are you receiving Black Lung (BL) Benefits?

___ Yes; Date benefits began: CCYY/MM/DD

BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.

___ No.

2. Are the services to be paid by a government program such as a research grant?

___ Yes; Government Program will pay primary benefits for these services

___ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

___ Yes.

DVA IS PRIMARY FOR THESE SERVICES.

___ No.

4. Was the illness/injury due to a work related accident/condition?

___ Yes; Date of injury/illness: CCYY/MM/DD

Name and address of WC plan:

Policy or identification number: _____

Name and address of your employer:

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS, GO TO PART III.

___ No. **GO TO PART II.**

Part II

1. Was illness/injury due to a non-work related accident?

___ Yes; Date of accident: CCYY/MM/DD

___ No. **GO TO PART III**

2. What type of accident caused the illness/injury?

___ Automobile.

___ Non-automobile.

Name and address of no-fault or liability insurer:

Insurance claim number: _____

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

___ Other

3. Was another party responsible for this accident?

___ Yes;

Name and address of any liability insurer:

Insurance claim number: _____

LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS
RELATED TO THE ACCIDENT. GO TO PART III.

___ No. **GO TO PART III**

Part III

1. Are you entitled to Medicare based on:

___ Age. **Go to Part IV.**

___ Disability. **Go to Part V.**

___ ESRD. **Go to Part VI.**

Part IV - Age

1. Are you currently employed?

___ Yes.

Name and address of your employer:

___ No. Date of retirement: CCYY/MM/DD

2. Is your spouse currently employed?

___ Yes.

Name and address of spouse's employer:

___ No. Date of retirement: CCYY/MM/DD

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?

___ Yes. ___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**

4. Does the employer that sponsors your GHP employ 20 or more employees?

___ Yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to patient: _____

___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

Part V - Disability

1. Are you currently employed?

___ Yes.

Name and address of your employer:

___ No. Date of retirement: CCYY/MM/DD

2. Is a family member currently employed?

___ Yes.

Name and address of your employer:

___ No.

**IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2,
MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO
QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.**

3. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?

___ Yes. ___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE
PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**

4. Does the employer that sponsors your GHP employ 100 or more employees?

 Yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to patient: _____

 No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

Part VI - ESRD

1. Do you have group health plan (GHP) coverage?

Name and address of GHP:

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

___ No. **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

___ Yes. Date of transplant: CCYY/MM/DD

___ No.

3. Have you received maintenance dialysis treatments?

___ Yes. Date dialysis began: CCYY/MM/DD

If you participated in a self-dialysis training program, provide date training started:
CCYY/MM/DD

___ No

4. Are you within the 30-month coordination period?

___ Yes

___ No. **STOP. MEDICARE IS PRIMARY.**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

___ Yes.

___ No. **STOP. GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**

6. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

___ Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**

___ No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement)?

 Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

 No. **MEDICARE CONTINUES TO PAY PRIMARY.**

If no MSP data are found in CWF for the beneficiary, the provider still asks the questions found in §20.1 and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process.

20.2.2 - Documentation to Support the Admission Process

(Rev. 1, 10-01-03)

HO-301.3

The provider retains a copy of completed admission questionnaires in its files (or online) for audit purposes to demonstrate that development for other primary payer coverage takes place. It is not necessary that the completed questionnaire be signed by the beneficiary.

Medicare permits providers to retain hard copy questions and responses on paper, optical image, microfilm, or microfiche. Hard copy and data must be kept for at least 10 years after the date of service that appears on the claim. (See Chapter 5 for information about the documentation to be used in a hospital review.) If the provider's admissions questions are retained online, Medicare requires it to retain **negative** and **positive** responses to admission questions for 10 years with DOJ's record retention requirements, after the date of service. Online data may not be purged before then.

30 - Provider Billing

(Rev. 1, 10-01-03)

30.1 - Health Care Provider Billing Where Services Are Covered by a GHP

(Rev. 1, 10-01-03)

A3-3491, A3-3491.6, A3-3491.6.B, A3-3490, A3-3490.12.B.1&2, HO-262.4, HO-263.1, HO-263.7, HO-264, HO-264.9, HO-289.11, SNF-327, SNF-332.4, SNF-335, SNF-335.9, SNF-336.1, SNF-336.7, HH-250.11, HH-251.4, HH-252, HH-252.9, HH-253.1, HH-253.7

Health care providers seek reimbursement from a GHP insurer before billing Medicare when there is an indication the insurer is primary payer. A GHP is billed first as primary

payer even where there may be primary coverage for only part of the stay or services (e.g., split stays where the beneficiary terminated employment during the stay and the GHP coverage terminated concurrently.)

When a health care provider bills a GHP as primary payer, the bill itemizes the services rendered even though they are services for which Medicare reimburses on a fee schedule, composite rate or other reimbursement methodology.

30.2 - Provider Billing Where Services Are Accident Related

(Rev. 1, 10-01-03)

A3-3489.2.B, HO-262.4, SNF-332.4, HH-251.4

If a provider learns that an automobile medical or no-fault insurance company may pay for covered services, it must bill the insurance company as the primary insurer.

30.2.1 - Health Care Provider Bills Automobile Medical or No-Fault Insurer First

(Rev. 1, 10-01-03)

A3-3489, A3-3408.1.B, HO-262.8, HO-262.10, HO-262.14, HO-289.12, SNF-327.1, SNF-334, SNF-334.2, SNF-334.6, HH-248, HH-248.2, HH-248.6, HH-250.12

If the services are related to an automobile accident, the provider ascertains whether its records show coverage under automobile medical or no-fault insurance. Where the records do not show such coverage, it contacts the beneficiary to ascertain whether such coverage exists. If a provider learns that an automobile medical or no-fault insurance may pay for otherwise covered services, it bills the insurance company as primary insurer.

If there is no coverage under automobile medical or no-fault insurance, but another insurer is shown on the bill, and there is indication of primary GHP coverage under Chapter 1, §§10.1, 10.2, or 10.3, the provider bills the other insurer for the services not paid. It may bill Medicare for secondary benefits as described below if the insurer does not pay in full.

If the services provided to the Medicare beneficiary are not related to an automobile accident and there is no indication of primary GHP coverage under Chapter 1, §§10.1 or 10.2, the provider bills Medicare for primary payment.

30.2.1.1 - No-Fault Insurance Does Not Pay

(Rev. 1, 10-01-03)

A3-3682.5.A, A3-3689.2, HO-262.11, HO-289.14, SNF-329, SNF-334.3, HH-248.3, HO-262.10, SNF-334.2, HH-248.2, HH-250.14

If the services are related to an accident and the no-fault insurer has been billed but does not make payment because the individual's no-fault benefits are exhausted or, the individual's coverage expired, primary Medicare payments may be made and the provider bills Medicare as usual.

The provider is instructed, when billing Medicare where a no-fault insurer has been billed but does not make payment, to bill Medicare and annotate the date on which the other payer denied the claim and the reason for denial. If the provider later receives payment from a no-fault insurer, it refunds the Medicare payment by submitting an adjustment bill.

Providers of services notify the intermediary of a No-Fault denial using occurrence code 24 (Date Insurance Denied) and indicate the date on which the other payer denied the claim. The reason for denial is indicated in remarks. In addition, the following occurrence codes are used to identify the date of the accident:

01 - Auto Accident and Date

02 - No-Fault Insurance Involved-Including Auto Accident/Other and Date

If the conditions described in Chapter 7, §50.2.2, are met, conditional payments may be made. To request a conditional payment, providers of service enter value code 14 with zero value in form locator 39-41 to indicate the type of other insurer and that conditional payment is requested. The identity of the other payer is shown on line A of item 50, and the identifying information about the insured is shown on line A of items 58-62. The provider enters the proper occurrence code in items 32-36 and the address of the insurer in item 38 or Remarks (item 84). In addition, an explanation of why the conditional payment is justified is shown in Remarks (item 84). (See Chapter 7, §50.2.2, for an explanation of policy and procedures for conditional payment situations for contested, delayed, or no-fault claims.)

30.2.1.2 - Liability Claim Also Involved

(Rev. 1, 10-01-03)

A3-3489.2B3, HO-289.5, HO-289.14, SNF-329, HH-250.14, SNF-325.5, HH-250.5, HO-262.10, SNF-334.2, HH-248.2

If the individual files a claim against a third party for injuries suffered in an accident, the provider bills Medicare for otherwise covered expenses to the extent that payment has not been made, or cannot be made promptly by a no-fault insurer or has not been made by a

liability insurer. For example, an individual incurs \$20,000 in medical expenses due to an automobile accident. The individual receives \$5,000 in no-fault insurance benefits and also has a liability claim pending against the driver of the other car. Medicare does not pay benefits for the \$5,000 in expenses paid for by the no-fault insurer but does pay benefits based on the additional \$15,000 in expenses. Medicare recovers from the liability insurer or the beneficiary when the liability claim is settled.

30.2.1.3 - No-Fault Payment is Reduced Because Proper Claim Not Filed

(Rev. 1, 10-01-03)

A3-3489.2.B.4, HO-262.10, SNF-334.2, HH-248.2

When a provider receives a reduced no-fault payment because of failure to file a proper claim, (see Chapter 1, §20 for definition), the Medicare secondary payment may not exceed the amount that would have been payable if the no-fault insurer had paid on the basis of a proper claim.

The provider must inform the contractor that a reduced payment was made and notify it of the amount that would have been paid if a proper claim had been filed. Failure to notify Medicare of the latter amount would constitute the filing of a false claim against the United States and could result in prosecution.

30.2.2 - Responsibility of Provider Where Benefits May Be Payable Under Workers' Compensation

(Rev. 1, 10-01-03)

A3-3408.1.A, A3-3408.2, HO-289.12, HO-289.13, HO-289.14, SNF-327.1, SNF-327.2, SNF-329, HH-250.12, HH-250.13, HH-250.14, A3-3408.4

Information supplied by the provider is one of the means of alerting the contractor to actual or potential WC coverage. A condition is work-related if it resulted from an accident that occurred on the job or from an occupational disease. The billing form is completed in accordance with Pub 100-4, Chapter 25, "Completing and Processing UB-92 Data Set," or Chapter 26, "Instructions for Completing Form CMS-1500 and the NSF Format," when any of the following apply:

- The provider, physician, or the patient states that the condition is work-related;
- The condition, or serious aggravation thereof, resulted from an accident which occurred in the course of the individual's employment, e.g., the patient fell from a scaffold while at work;
- The diagnosis is one which is commonly associated with employment, e.g., pneumoconiosis (including silicosis, asbestosis, and "black lung" disease in the case of a coal miner); radiation sickness, anthrax, undulant fever; dermatitis due to contact with industrial compounds; and lead, arsenic, or mercury poisoning;

- The beneficiary previously received WC for the same condition;
- There is indication that a WC claim is pending; or
- There is other indication that the condition arose on the job.

Where there is an indication that WC may pay for the services, the provider bills the WC carrier. If WC pays for all of the services (whether at the provider's customary charge rate or at a special WC rate) the provider submits a Medicare bill indicating the insurer paid in full. The beneficiary's Medicare deductible will be credited, however no payment will be made.

If the provider's WC claim is denied, the provider determines whether any other MSP provisions apply and bills accordingly. If no other primary payers are available, the provider submits:

- A bill in accordance with the regular billing procedures indicating occurrence code 24 (insurance denied) and the date of denial in Items 36; and
- A supplementary statement calling attention to the fact that WC has denied payment or annotates Item 84, remarks, with the reason.

30.2.3 - Responsibility of Provider Where Benefits May be Payable Under the Federal Black Lung (BL) Program

(Rev. 1, 10-01-03)

A3-3408.3, HO-289.14, HO-289.18, SNF-329.3, SNF-329, HH-250.14, HH-250.18

Providers are to identify beneficiaries who may be entitled under the Federal Black Lung (BL) Program. Where it appears that a beneficiary may be entitled to receive medical benefits under the Federal BL Program administered by DOL, the provider bills DOL in the following situations:

- **Diagnosis Is BL Related** - The provider bills **all** services to DOL, and includes its DOL assigned provider number on the billing form.
- **Diagnosis Is Not BL Related** - The bill is for an inpatient stay during which some BL covered procedures were furnished. The provider bills all services to DOL.
- The bill is for outpatient services that include one or more BL related procedures. The provider bills DOL only for those procedures that are reimbursable under the BL program.
- **DOL Does Not Pay for All of the Services** - If a provider bills DOL, but DOL doesn't pay for the services in full, the provider bills Medicare as provided in the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing UB-92 (CMS-1450) Data Set," attaching a copy of DOL's denial notice which gives the specific reason for nonpayment. If a claim is denied because of the

provider's failure to obtain a DOL provider number or to furnish documentation needed by DOL, payment may not be made under Medicare.

30.3 - Provider Billing Medicare for Secondary Benefits

(Rev. 1, 10-01-03)

A3-3492.E, A3-3408, SNF-337

If a GHP pays primary benefits, secondary Medicare benefits may be payable in accordance with Chapter 2, §10, to supplement the amount paid by the GHP. Medicare secondary benefits may be payable if the following situations apply:

- The plan payment is less than the provider's charges for Medicare covered services;
- The plan payment is less than the gross amount payable by Medicare; and,
- The provider does not accept and is not obligated to accept the GHP primary payment as payment in full.

When a provider bills Medicare for secondary benefits, the primary payment amounts are reported according to §40.1.1 and §40.1.2. If a GHP denies a claim for primary benefits, the provider submits a bill for conditional primary benefits with an explanation of any reason given by the plan for its denial. For an inpatient hospital or SNF stay, if the GHP's payment equals or exceeds the gross amount payable by Medicare (as defined in Chapter 2, §50.2), or equals or exceeds the provider's charges for Medicare covered services or the provider accepts or is obligated to accept the GHP payment as payment in full, a no payment bill is submitted in accordance with Chapter 5, §§40.8.

Any excess of the GHP payment over the gross amount payable by Medicare is not deducted from the provider's Medicare reimbursement at final cost settlement. If the GHP denies a provider's claim for primary benefits, the provider submits a claim for primary Medicare benefits or conditional primary benefits as provided for in Chapter 5, §40.3.1.

30.4 - Instructions to Providers On How to Submit Claims to a Medicare Intermediary When There Are Multiple Primary Payers

AB-03-011

There are situations where there is more than one primary payer that pays on a Medicare Part A electronic claim and Medicare may still make a secondary payment on the claim. When there are multiple primary payers, providers must do the following when sending the claim to Medicare for secondary payment.

- Comply with Section 1.4.2, titled “Coordination of Benefits,” found in the 837 version 4010 Institutional Implementation Guide regarding the submission of

Medicare beneficiary claims to multiple payers for payment. Follow model 1 in Section 1.4.2.1 that discusses the “provider to payer to provider” methodology of submitting electronic claims.

- After receiving the electronic remittance advice from the primary payers, the provider sends the other payers’ claim information to Medicare using the 837 version 4010 format. For MSP claims, they place the primary payer paid amounts, in loop 2300, qualifier HIXX-1 = BE. They place the value codes in HIXX-2 and the (value code) monetary amounts in HIXX-5. **NOTE:** In regard to Value Code 44, Obligated to Accept as Payment in Full (OTAF) amount, indicate a value of “Y” in loop 2320, segment OI03. This will inform Medicare that an OTAF amount is present on the claim and the amount can be found in the 2300 loop HI segment.
- If, for any reason, the provider must send a hardcopy MSP claim, they must place the MSP Value codes and Value code amounts in FL 39-41 of the Form UB92/1450.

30.5 - Instructions to Physicians and Suppliers On How to Submit Claims to a Medicare Carrier When There Are *One or More* Primary Payers

(Rev. 21, Issued: 10-29-04, Effective:04-01-05, Implementation: 04-04-05)

AB-03-011 *and B-03-050*

A - When Medicare is the Secondary Payer (MSP) Following One Primary Payer

There are situations where one primary payer pays on a Medicare Part B claim and Medicare may make a secondary payment on the claim. Physicians and suppliers must comply with Section 1.4.2, titled “Coordination of Benefits,” found in the 837 version 4010A1 Professional Implementation Guide (IG) regarding the submission of Medicare beneficiary MSP claims (The IG can be found at http://hipaa.wpc-edi.com/HIPAA_40.asp). Physicians and suppliers must follow model 1 in section 1.4.2.1 that discusses the provider-to-payer-to-provider methodology of submitting electronic claims. Physicians and suppliers must use the appropriate loops and segments to identify the other payer paid amount, allowed amount, and the obligated to accept payment in full amount on the 837 as identified below:

Primary Payer Paid Amount:

For line level services, physicians and suppliers must indicate the primary payer paid amount for that service line in loop ID 2430 SVD02 of the 837.

For claim level information, physicians and suppliers must indicate the other payer paid amount for that claim in loop ID 2320 AMT02 AMT01=D of the 837.

Primary Payer Allowed Amount:

For line level services, physicians and suppliers must indicate the primary payer allowed amount for that service line in the Approved Amount field, loop ID 2400 AMT02 segment with AAE as the qualifier in the 2400 AMT01 segment of the 837.

For claim level information, physicians and suppliers must indicate the primary payer allowed amount in the Allowed Amount field, Loop ID 2320 AMT02 AMT01 = B6.

Obligated to Accept as Payment in Full Amount (OTAF):

For line level services, physicians and suppliers must indicate the OTAF amount for that service line in loop 2400 CN102 CN 101 = 09. The OTAF amount must be greater than zero if there is an OTAF amount, or if OTAF applies.

For claim level information, physicians and suppliers must indicate the OTAF amount in loop 2300 CN102 CN101 = 09. The OTAF amount must be greater than zero if there is an OTAF amount, or if OTAF applies.

B - When Medicare is the Secondary Payer Following Multiple Primary Payers

There may be situations where more than one primary insurer to Medicare makes payment on a claim; for example, an employer group health plan makes a primary payment for a service and, subsequently, another group health plan also makes a primary payment for the same service. Claims with multiple primary payers cannot be sent electronically to Medicare. A hardcopy claim must be submitted on Form CMS-1500. Physicians and suppliers must attach the other payers' EOB, or remittance advice, to the claim when sending it to Medicare for processing.

C – Submission of MSP Claims With Multiple Primary Payers Where There is More Than One Insurance Type Code

When a carrier receives claims with more than one insurance type code, the carrier must send the shared system and CWF the insurance type code associated with the highest other payer total claim payment amount. For example, a Medicare beneficiary sustains injury in a car accident. Five services were performed on the beneficiary. Since the services performed were related to the accident, the automobile insurer (referred to as insurance type code 14) makes a \$500.00 payment on each line of the claim totaling \$2,500.00. The beneficiary also has coverage through the spouse's employer health plan. The spouse's plan (referred to as insurance type code 12) makes a \$400.00 payment on each line of the claim totaling \$2000.00. The carrier must send insurance type code 14 (not insurance type code 12) to the shared system and CWF.

D - Amounts Carriers and Shared Systems must send MSPPAY on electronic and paper claims with one or more Primary Payers

There are situations with MSP claims when the 1) the primary payer allowed amount(s) are greater than the billed amount; 2) the primary paid amount(s) are greater than the

When the other insurer paid amount, or combined paid amount exceeds the physician or supplier billed amount, the shared systems shall send the billed amount in place of the primary payer's paid amount to MSPPAY and CWF.

When the primary payer allowed amount exceeds the physician or supplier's billed amount, the shared systems shall send the billed amount in place of the primary payer allowed amount to MSPPAY.

When the primary paid amount is greater than the primary allowed amount, and less than billed charges, the shared systems shall send the primary payer paid amount instead of the primary allowed amount to MSPPAY.

When the primary payer paid amount exceeds the primary payer contractual amount, the shared system shall send the primary payer contractual amount instead of the primary payer paid amount to MSPPAY.

The remittance advice shall show the billed amount, the Medicare payment amount, and the "impact amounts" from the primary payer(s) on which the Medicare payment is based, and all Medicare adjustments. The impact amount, as found in 2.2.13 of the 835 Implementation Guide, is defined as the amount on which Medicare's payment is based. This amount will depend on the payment methodology followed in the above business requirements.

Shared Systems shall no longer use reason code 35 on the outbound remittance advice unless the life time benefit has been reached is the reason the claim is being adjusted. Shared systems instead shall use Group Code "CO" with Reason Code "45" on the outbound remittance advice when the OTAF amount minus the other payer's payment is the lowest of the three MSP calculations and is used to identify Medicare's Secondary payment.

NOTE: *In regards to the outbound 837, when the primary payment is equal to or exceeds the billed amount, and Medicare's payment is equal to zero, the outbound 837 shall show Medicare's zero payment in the 2320 AMT segment. The shared systems shall identify in the CAS segment of the outbound 837 the amount that exceeds the billed amount and the reason why Medicare is making a zero payment by using group code and claims adjustment reason code CO 94 (processed in excess of charges), with an accompanied negative dollar amount, and OA 23 (payment adjusted because charges have been paid by another payer) with an accompanied negative dollar amount.*

E - When a carrier receives a hard copy claim with multiple primary payer amounts.

Carriers must take into consideration instructions found in 30.5.D above when sending the correct amounts to MSPPAY for payment calculation.

Primary Payer Paid Amounts: For line level service claims, the carrier must add all primary payer paid amounts for that service line and send the total line level payment amount to MSPPAY. If only claim level information is sent to Medicare, the carrier adds all other payer paid amounts for that claim and send the total claim payment amount to MSPPAY. *Note: If the payment amount is greater than the billed amount, send the billed amount to MSPPAY instead of the other payer paid amount.*

Primary Payer Allowed Amount: For line level services, carriers use one of the two fields as follows:

- Either the higher of the allowed amount for that service line, or
- The total of the other payer paid amounts, whichever is higher, and send it to MSPPAY.

If only claim level information is sent to Medicare, carriers use one of the two fields as follows:

- Take the total claim level allowed amount, or
- The total of the paid amount, *if less than the billed amount*, whichever is higher, and send it to MSPPAY.

Obligated to Accept as Payment in Full Amount (OTAF): For line level services, the carrier takes the lowest OTAF amount for that service line, which must be greater than zero, and sends that amount to MSPPAY. If only claim level information is sent to Medicare, the carrier takes the lowest claim level OTAF amount, which must be greater than zero, and sends it to MSPPAY. (**NOTE:** If submitted charges are lower than the OTAF amount, they send the lowest Medicare covered charge for that service line to MSPPAY.)

Claim Example:

Below is an example of a hard copy Part B MSP claim, with more than one *primary payer*, sent to a Medicare carrier. All services are Medicare covered services.

Payer 1	Submitted Covered Charges	Other Payer Allowed Amount (Medicare Part B only)	OTAF	Other Payer Paid Amount
Line 1	\$60.00	\$60.00	\$50.00	\$40.00
Line 2	\$40.00	\$30.00	\$30.00	\$30.00

Total	\$100.00	\$90.00	\$80.00	\$70.00
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Payer 2	Submitted Covered Charges	Other Payer Allowed Amount (Medicare Part B only)	OTAF	Other Payer Paid Amount
Line 1	\$60.00	\$50.00	\$50.00	\$40.00
Line 2	\$40.00	\$30.00	\$0	\$30.00
Total	\$100.00	\$80.00	\$50.00	\$70.00

The carrier must send the following line level other payer amounts to MSPPAY based on the instructions cited above.

Line 1:	Other Payer Allowed Amount (Part B):	<i>\$60.00</i>
	OTAF:	\$50.00
	Other Payer Paid Amount:	<i>\$50.00 (the OTAF amount is substituted for line1)</i>
Line 2	Other Payer Allowed Amount (Part B)	<i>\$40.00</i>
	OTAF:	\$30.00
	Other Payer Paid Amount	<i>\$30.00 (the billed amount is substituted for line1)</i>

Based on the example above, since Payer 2 had no OTAF amount on service line 2 and Payer 1 had an OTAF amount greater than zero on service line 2, Payer 1's OTAF of \$30.00 is used and sent to MSPPAY. *Since the combined payment amount is higher than the primary payer OTAF amount for Line 1 and line 2, the OTAF amounts are sent to MSPPAY in place of the paid amounts.*

40 - Completing the Form CMS-1450 in MSP Situations by Providers of Service

(Rev. 1, 10-01-03)

A3-3682 (The references to item numbers in this section were changed from UB-82 to UB-92 or eliminated if field names were adequate). **HO-264.9, HO-469, HO-471, SNF 569, SNF-571, SNF-572, HH-494, SNF-335.9, HH-252.9, HO-472, HO-475, HO-470, SNF-570, HH-495, HH-496, HH-497**

Where Medicare is determined to be the primary payer, Medicare is shown on line A of FL 50. Where Medicare is secondary, Medicare is shown on line B. All bills where Medicare is secondary because of primary payer coverage are prepared in accordance with the following instructions.

40.1 - Full Payment by the Primary Payer

(Rev. 1, 10-01-03)

A3-3682.1, A3-3682.3, HO-472.1, HO-472.3, HH-264.11, SNF-335.11, HH-252.11

40.1.1 - Inpatient Services

(Rev. 1, 10-01-03)

If payment by the primary payer for Medicare covered services (as determined by the formula in §40.2.2) equals or exceeds the provider's charge for those services or the current Medicare interim payment amount (without regard to deductible or coinsurance), or the provider accepts or is obligated to accept the primary payer payment as payment in full and receives at least this amount, no payment is due from Medicare, and no utilization is charged to the beneficiary. However, the provider submits a no-payment bill for determining the benefit period. In addition, primary payer payments are used to satisfy unmet deductibles. The intermediary shall process the bill in accordance with Chapter 5, Contractor Prepayment Processing Requirements, and as follows:

- The provider completes the total and noncovered charges columns as if there had been no other payment;
- Where blood is involved, the provider completes the blood items. (This data is for the beneficiary's utilization records only and is not to be used for the Provider Statistical & Reimbursement [PS&R] Report);

- The provider does not complete the coinsurance amount (no days are charged). However, inpatient deductible and total deductions are completed when applicable. (This data is for the beneficiary's utilization records only and is not to be used for the PS&R Report.);
- The provider shows total covered and noncovered days in the usual manner. The intermediary counts days paid by the primary payer as covered days;
- The provider enters the appropriate value code to identify the primary payer;
- The provider enters the amount paid by the primary payer in the Value Amount field;
- The provider enters condition code 77 in the condition code field when it receives an amount it is obligated to accept from the primary payer as payment in full;
- The intermediary does **not** complete the nonpayment code;
- The intermediary enters the additional MSP data elements that may apply to the bill based on the applicable MSP provision according to §40.3 below.

40.1.2 - Outpatient Bills, Part B Inpatient Services, and HHA Bills

(Rev. 1, 10-01-03)

A3-3682, A3-3682.4, HO-264.9, HO-469, HO-472, HO-472.2, SNF-335.9, SNF-569, HH-494, HH-252.9

No bill is submitted if:

- Payment by the primary payer for Medicare covered services (as determined by the formula in subsection B3) equals or exceeds:
 - The provider's charges for those services, or
 - The current Medicare interim payment amount (without regard to the deductible or coinsurance), or the provider accepts (or is obligated to accept) the primary payer's payment as payment in full (and it receives at least this amount) and the provider knows the individual has already met the deductible.
- A GHP payment for an ESRD beneficiary equals or exceeds the composite rate (without regard to the deductible or coinsurance) and the hospital-based renal dialysis facility knows the individual has **met the deductible**; and
- Where a HHA is billing for DME or orthotic/prosthetic devices and the patient is not under a plan of treatment and the provider knows the individual has met the deductible.

A bill is submitted to:

- Inform Medicare of charges where the deductible may not yet be met. Although Medicare can make no payment, it can apply the expenses to the beneficiary's deductible. A bill is required for crediting the deductible.

The provider of service completes the bill in the usual manner and determines the charges including those covered by the primary payer's payment. The amount paid by the primary payer for Medicare covered services is reported in the appropriate value code and amount. See §40.2 below for additional MSP data elements that may apply to the bill based on the applicable MSP provision. The provider of service enters condition code 77 when it receives the amount it is obligated to accept from the primary payer as payment in full.

40.2 - Partial Payment by Primary Payer

(Rev. 1, 10-01-03)

A3-3682.1.B, HO-263.11, SNF-336.11, HH-253.11, (HH-264.10, SNF-335.10, HH-252.10 superseded by IM 3497.2)

40.2.1 - Partial Payment by Primary Payer for Inpatient Services, Outpatient Services, Part B Inpatient Services, and HHA Bills

(Rev. 1, 10-01-03)

A3-3682.1.B, HO-472.3

A modified bill will be submitted if payment by the primary payer for Medicare covered services (as determined by the formula in B3) is less than the provider's charges for those services and the current Medicare interim payment amount (without regard to the deductible or coinsurance) and the provider does not accept (and is not obligated to accept) the primary payer's payment as payment in full, or the primary payment is less than the composite rate (without regard to the deductible and coinsurance),

The bill will be submitted in accordance with Chapter 25, "Completing and Processing UB-92 Data Set," of the Medicare Claims Processing Manual, with the following modifications:

- The provider completes the total and noncovered charges as if there had been no other payment;
- For inpatient hospital or SNF services, the provider completes total covered and non-covered days in the usual manner. It counts days paid by the primary payer as covered days;

- The primary payer is identified on the first payer line in FL 50. Medicare is identified as the secondary or tertiary payer by completing the second or third payer line;
- The appropriate primary payer value code and amount paid is shown in value code and amount fields;
- The amount the provider is obligated to accept as payment in full from the primary payer when the primary payer pays a lesser amount is shown as value code 44;
- The address of the primary payer is shown in Remarks (FL 84); and
- If the primary payer is a GHP for an ESRD beneficiary, the provider enters occurrence code 33 and the first day of the first month of the Medicare coordination period. In addition, the provider enters the appropriate occurrence/condition codes in §40.3 below.

40.2.2 - Partial Payment by Primary Payer That Applies to Medicare Covered Services

(Rev. 1, 10-01-03)

A3-3682.2.B, A3-3682.2.B.3, A3-3682.1.B.5, A3-3682.3.B.5, A3-3682.4.B.3, A3-3682.5, A3-3685.A.2, HO-264.9, HO-472, HO-472.3, SNF-335.9, HH-252.9

The provider indicates the primary payer's allocation of its payment between covered and non-covered Medicare services, by entering the amount the primary payer paid toward Medicare covered services in value codes (FLs 39 - 41) and value amount fields on the Form CMS-1450. Where the provider cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes/amounts (FLs 39-41). It treats all services (other than those for which the beneficiary may be charged, such as a private room that is not medically necessary) furnished on any day for which benefits are payable as covered. It must be able to validate its ratio of covered and non-covered charges if requested.

If a benefit exhausted case is also a day outlier, Medicare covered charges cannot be determined until the impact of the primary payment on utilization is determined. See subsection A4 for determining covered charges in this situation.

NOTE: Day Outlier provisions became obsolete after FY 1997.

EXAMPLE 1

Total charges were \$110. Medicare covered charges were \$90. The primary payer's payment was \$88. Since the provider cannot determine the actual allocation of the

primary payer's payment, it uses the following calculation to determine the allocation shown below:

$$(\$90 \text{ divided by } \$110) \times \$88 = \$72$$

The provider enters \$72 in value code/amounts (Items 39-41).

EXAMPLE 2

Total charges were \$5,000. Medicare covered charges were \$4,000. The primary payer's payment was \$3,000. Since the non-PPS provider of service cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$(\$4,000 \text{ divided by } \$5,000) \times \$3,000 = \$2,400$$

The non-PPS provider of service enters \$2,400 in the value code amount.

EXAMPLE 3

Total charges were \$550. Medicare covered charges were \$500. The primary payer's payment was \$330. Since the HHA cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$(\$500 \text{ divided by } \$550) \times \$330 = \$300$$

The HHA enters \$300 in the value code amount.

40.3 - Annotation of Claims Denied by GHP's, Liability or No-Fault Insurers

(Rev. 1, 10-01-03)

A3-3491.9.D, A3-3682.5, HO-263.10, HO-472.3, SNF-336.10, HH-253.10

Primary Medicare benefits are paid (if the beneficiary is not appealing the GHP denial) when a single or a multiple employer plan for which CMS has approved the plan's multi-employer exemption request denies a claim for primary benefits because:

- The beneficiary is age 65 or over and is enrolled in a single employer plan of an employer who does not employ 20 or more employees;
- The beneficiary is age 65 or over and is enrolled in a multi-employer plan by virtue of employment with an employer that does not employ 20 or more employees and the plan has elected the small employer exception;
- The beneficiary is not entitled to primary benefits under the plan;

- The beneficiary is under age 65 and disabled and the employer does not employ 100 or more employees and the employer is not a member of a multiple employer GHP which has at least one employer that employs 100 or more employees;
- The beneficiary is not entitled to benefits under the plan on the basis of rules that apply equally to all participants without regard to age or Medicare entitlement;
- Benefits under the GHP are exhausted for the services involved;
- The services are not covered by the GHP under any circumstances for any covered individual;
- The beneficiary has Medicare based on ESRD (under age 65 and eligible based on ESRD) and not in a Medicare coordination period.

Medicare does not pay primary Medicare benefits if it is believed that the GHP covers the particular service and the plan asserts that the services are not covered for “primary payment” when provided to Medicare beneficiaries.

Where a GHP denies payment for any of these reasons, the provider shows occurrence code 24 or 25 (insurance denied) and the date of denial in FLs 32-35 (occurrence codes). In addition, it provides the reason for the denial in Remarks (FL 84).

Medicare primary benefits cannot be paid when a GHP offers only secondary coverage of services covered by Medicare and it does not allege that the employer has fewer than 20 employees (or 100 employees in the case of disabled beneficiaries). The provider enters occurrence code 24 (insurance denied) and the date of denial in FLs 32-35 (occurrence codes). In addition, it enters the annotation "Plan offers secondary coverage of services covered by Medicare."

40.3.1 - Annotation of Claims to Request Conditional Payments

(Rev. 1, 10-01-03)

A3-3682.5, HO-289.21, SNF-330, HH-250.20

When a liability or no-fault insurer does not make payment e.g., the services are not covered under no-fault insurance or the individual's insurance coverage expired, the provider bills Medicare as usual. In addition, the proper occurrence code as indicated below is shown in FLs 32-35. Occurrence code 24 is completed to show the date the other payer denied the claim, and the reason for denial is shown in Remarks (FL 84).

A conditional primary payment may be requested if conditional payment criteria are met.

The provider enters value code 14 with a zero value amount in FLs 39-41 to indicate the type of other insurer and that conditional payment is requested. The identity of the other payer is shown on line A of FL 50, and the identifying information about the insured is shown on line A of FLs 58-60. The provider enters the proper occurrence code in FLs 32-35 and the address of the insurer in FL 38 or Remarks (FL 84). In addition, an

explanation of why the conditional payment is justified is shown in Remarks (FL 84). (See Chapter 7, §50.2.2 for an explanation of policy and procedures for conditional payment situations for contested, delayed, or no-fault claims.)

When a GHP insurer does not make payment for the reasons described below, a conditional Medicare payment can be requested. Conditional payments may be requested where:

- The provider has filed a proper claim under the plan and the plan denies the claim in whole or in part; or
- The provider fails to file a proper claim because of the physical or mental incapacity of the beneficiary.

The provider requests conditional primary payment by entering the appropriate value code to indicate the type of other insurer. Applicable GHP value codes are 12, 13 or 43. The value amount is completed with zero value in FLs 39-41. In addition, it includes occurrence code 24 (insurance denied) and the date of denial by the GHP. The identity of the GHP is entered on line A of FL 50, the identifying information about the insured is entered on line A of FLs 58-62, and the address of the GHP is entered on FL 38 or Remarks (FL 84). In addition, the provider enters the annotation "Beneficiary has appealed or is protesting GHP denial" in Remarks, FL 84.

Neither primary benefits nor conditional primary Medicare payments may be made where a GHP denies payment for particular services on the grounds they are not covered by the plan, and the contractor believes the plan does cover them. Conditional benefits are not paid if a plan offers only secondary coverage for services covered by Medicare, and the GHP does not allege that the employer has fewer than 20 employees. Conditional primary benefits are not paid even if the GHP has only collected premiums for secondary rather than primary coverage. Where a GHP has denied the claim because the plan provides only secondary coverage, the contractor denies the claim for Medicare primary benefits unless the single employer GHP or multi-employer plan with an approved multiple employer plan exemption alleges that the employer has fewer than 20 employees.

50 - Summary of MSP Data Elements for Form CMS-1450 (UB-92)

(Rev. 1, 10-01-03)

The following table identifies the data elements that are submitted on bills to communicate the status of the primary payer and payment where Medicare is the secondary payer. See Medicare Claims Processing Manual, Chapter 25, "Completing and Processing UB-92 Data Set," for a crosswalk to the electronic data elements or segment names.

Data Element	Value for MSP	MSP Situation
Condition Code		
02-Employment Related		Workers' Compensation and Black Lung
05-Lien has been filed		WC, No-fault, Liability,
06-ESRD Patient within coordination period and covered by GHP		End Stage Renal Disease and covered by a GHP
08-Beneficiary would not furnish information concerning other insurance coverage		All MSP situations
09-Neither patient nor spouse is employed		Working Aged, Disability, or ESRD
11-Disabled Beneficiary but no GHP exists		Disability
28-Patient and/or Spouse's GHP is Secondary to Medicare		Working Aged
29-Disabled Beneficiary and/or Family Member's GHP is Secondary to Medicare		Disability
77-Provider Accepts Payment by a Primary Payer as Payment in Full		All MSP Situations
D7-Claim Change Reason Code for Adjustment Requests to Make Medicare the Secondary Payer		All MSP Situations
D8-Claim Change Reason Code for Adjustment Requests to Make Medicare the Primary Payer		All MSP Situations
Occurrence Code and Date		
01-Auto Accident		No-Fault or Liability
02-No-fault Insurance including Auto accident/Other		No-Fault
03-Accident/Tort Liability		Liability
04-Accident/Employment Related		WC or BL
05-Other Accident		Liability

Data Element	Value for MSP	MSP Situation
18-Date of Retirement		Working Aged, Disability, or ESRD
19-Date of Retirement Spouse		Working Aged, Disability, or ESRD
24-Date Insurance Denied		All MSP Situations
25-Date Benefits Terminated by Primary Payer		All MSP Situations
33-First day of the Medicare coordination period for ESRD beneficiaries covered by GHP		ESRD
A1-Birth date -Insured A		Working Aged, Disability, or ESRD
A2-Effective Date-Insured A Policy		Working Aged, Disability, or ESRD
A3- Benefits Exhausted for Payer A		Working Aged, Disability, or ESRD
B1-Birth date -Insured B		Working Aged, Disability, or ESRD
B2-Effective Date-Insured B Policy		Working Aged, Disability, or ESRD
B3- Benefits Exhausted for Payer B		Working Aged, Disability, or ESRD
C1-Birth date -Insured C		Working Aged, Disability, or ESRD
C2-Effective Date-Insured C Policy		Working Aged, Disability, or ESRD
C3- Benefits Exhausted for Payer C		Working Aged, Disability, or ESRD

Value Codes and Amounts

12- Working Aged Beneficiary/Spouse Group Health Plan	Working Aged
13-ESRD Beneficiary in a Medicare Coordination Period with an Employer Health Plan	ESRD
14-No-fault, including auto/other.	No-Fault
15-Workers' Compensation Six zeros in the amount field indicates a request for a conditional Medicare payment.	WC

Data Element	Value for MSP	MSP Situation
	16-PHS, Other Federal Agency	Other Federal Agency, VA
	41-Black Lung Six zeros in the amount field Black Lung indicates a request for a conditional Medicare payment.	
	42-Veterans Affairs	VA
	43-Disabled Beneficiary Under Age 65 with Disability GHP	
	44-Amount Provider Agreed to Accept from All MSP Provisions Primary Payer as Payment in Full	
	47- Any Liability Insurance	Liability Provisions
Insured's Name		
	For Primary Payer Information	All MSP Provisions
Patient's Relationship to Insured		
	01-Patient is Insured	All MSP Provisions
	02-Spouse	All MSP Provisions
	03- Natural Child/Insured has Financial Responsibility	Disability, ESRD
	08- Employee	Working Aged, ESRD, Disability
	15-Injured Plaintiff	Liability
Certificate/Social Security Number HI Claim ID Number		
	The involved claim number for the primary coverage is shown	All MSP Provisions
Insurance Group Number		
	Identification number	All MSP Provisions

Data Element	Value for MSP	MSP Situation
Employment Status Code		
1-Employed Full Time		Working Aged, ESRD, Disability
2-Employed Part-Time		Working Aged, ESRD, Disability
3-Not Employed		Working Aged, ESRD, Disability
4-Self-employed		Working Aged, ESRD, Disability
5-Retired		Working Aged, ESRD, Disability
Employer Name		
		WC, Working Aged, ESRD, Disability
Employer Location		
		WC, Working Aged, ESRD, Disability
Payer ID		
		All MSP Provisions

60 - Completing the Form CMS-1500 in MSP Situations by Suppliers of Services

(Rev. 1, 10-01-03)

B3-4020.1

Instructions for completing the Form CMS-1500 can be found in Pub 100-4, Chapter 26, "Completing and Processing Form CMS-1500 Data Set," of the Medicare Claims Processing Manual. Specific data elements used to report MSP information are listed below. In addition, each claim must have an EOB from the primary payer attached that identifies the amount allowed, paid, or denied by the primary payer.

Item	Data Element Name	Instruction to Provider
Item 4	Insured's Name	If the patient has insurance primary to Medicare, either through the patient's or the spouse's employment or any other source, the biller lists the name of the insured here. When the insured and the patient are the same, the biller enters the word SAME. If Medicare is primary this item is

Item	Data Element Name	Instruction to Provider
		left blank.
Item 7	Insured Address	The insured's address and telephone number. When the address is the same as the patients, the biller uses the word SAME. It completes this item only when items 4 and 11 are completed.
Item 8	Patient Status	The patient's marital status and whether employed or a student.
Item 9	Other Insured Name;	<p>The last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, the biller uses the word SAME. If no Medigap benefits are assigned, the biller leaves this item blank. This field may be used in the future for supplemental insurance plans.</p> <p>Participating physicians and suppliers taking assignment under a MEDIGAP policy complete this item.</p> <p>Other supplemental claims are not listed here because they are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.</p>
9a	Other Insured's Policy or Group Number	Item 9a. The policy and/or group number of the Medigap insured preceded by: MEDIGAP, MG, or MGAP.
9b	Other Insured's Date of Birth	Item 9b. The Medigap insured's 8-digit birth date (MMDDCCYY) and sex.
9c	Employer's Name or School Name;	Item 9c. Blank if a Medigap PayerID is in item 9d. Otherwise, the claims processing address of the Medigap insure.
9d	Insurance Plan Name or Program Name	Item 9d. The 9-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, then the Medigap insurance program or plan name is shown.
Item 10a	Is Patient's Condition Related to Employment?	Items 10a thru 10c. "YES" or "NO" must be checked to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. The State postal code must be

Item	Data Element Name	Instruction to Provider
Item 10b	Is Patient's Condition Related to Auto Accident?	shown. Any item checked "YES" indicates there may be other insurance primary to Medicare. Primary insurance information must then be shown in item 11.
Item 10c	Is Patient's Condition Related to Other Accident?	
Item 11	Insured's Policy Group or FECA Number	If there is insurance primary to Medicare, the biller enters the insured's policy or group number.
Item 11a	Insured's Date of Birth	Insured's 8-digit birth and sex if different from item 3
Item 11b	Employer's Name or School Name	The name of the insured's employer is shown here. If there is a change in the insured's insurance status, e.g., retired, this contains a retirement date preceded by the word "RETIRED".
Item 11c	Insurance Plan or Program Name	The 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, the complete primary payer's program or plan name. If the primary payer's EOB does not contain the claim processing address, this contains the primary payer's claims processing address as shown on the EOB.